



Vishwa Hindu Parishad of America Inc.: Vivekananda Family Camp

Medical-1

### Health History and Medical Form

Please fill out both pages of this form carefully and in detail.

Your doctor's office must sign at the bottom of page 2. Please attach sheet for additional information.

Please complete **a separate** form for each participant: Volunteer, Camper or Accompanying Child.

Name of Participant: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_

*First Middle Last*

Date of Birth (mo/day/yr): \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent or Guardian (reqd. for under 18): \_\_\_\_\_

Mother's/Wife's Name & Work and cell Tel: \_\_\_\_\_

Father's/Husband's Name & Work and cell Tel: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact's Phone(s): \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Medical Insurance co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Insured Parent: \_\_\_\_\_

**Please attach a copy of both sides of the insurance card.**

**Attach Immunization Record (mandatory for all under 18, can be obtained from child's physician's office, typically would include MMR, Polio, DPT and Hep-B).**

Adults (in case immunization record is not available): \_\_\_\_\_ (date of last tetanus shot): \_ (over 10 years ago)

**Health History: Check those that apply and explain any illness checked below or attach a sheet:**

Chicken Pox	___ Yes	___ No	Learning Difficulties	___ Yes	___ No
Measles	___ Yes	___ No	Physical/Social/Emotional Needs	___ Yes	___ No
German Measles	___ Yes	___ No	Hypertension	___ Yes	___ No
Mumps	___ Yes	___ No	Asthma	___ Yes	___ No
Mononucleosis	___ Yes	___ No	Bleeding Disorders	___ Yes	___ No
Seizure	___ Yes	___ No	Diabetes	___ Yes	___ No
Epilepsy	___ Yes	___ No	Operations/Serious Injuries.	___ Yes	___ No
Ear Infection	___ Yes	___ No	Chronic/Recurring Illness	___ Yes	___ No
Heart Disease/Defect	___ Yes	___ No	Dietary Restrictions	___ Yes	___ No
Musculoskeletal Disorder	___ Yes	___ No			

**Allergies (list)**

Food	___ Yes	___ No	Animal	___ Yes	___ No
Drug	___ Yes	___ No	Hay Fever	___ Yes	___ No
Insect Sting	___ Yes	___ No	Plant/Pollen	___ Yes	___ No

Other: \* \_\_\_\_\_  
\_\_\_\_\_



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Medical-2

### Health History and Medical Form

Please fill out both pages of this form carefully and in detail.

Your doctor's office must sign at the bottom of page 2. Please attach sheet for additional information.

Please complete a **separate** form for each participant: Volunteer, Camper or Accompanying Child.

Name of Participant: \_\_\_\_\_  
Special Conditions to be watched for (i.e. wetting, fainting, menstrual cramps, etc.) \*: \_\_\_\_\_

Hospital / Emergency visit during the last 6 months? : \_\_\_\_Yes: \_\_\_\_No: If yes then for what reason? \* \_\_\_\_\_

This health history is correct as far as I know and the person described has permission to engage in all camp activities except as noted above. I will notify Camp authority if there is any change in health conditions of the participant.

**I give permission:**

- 1) To the medical personnel selected by the Camp authority to hospitalize, secure proper treatment such as anesthesia or surgery, and to provide or arrange necessary transportation for the participant.
- 2) For Camp Health Supervisor to treat minor injuries or illness as directed by orders of a licensed physician; administer prescription medication brought to camp in it's original container, labeled with the participant's name, physician' name and dosage; and/or administer over- the- counter medication unless otherwise specified below.

**Medications:** List of over-the-counter medication that *may not* be administered to the participant: \*  
\_\_\_\_\_  
\_\_\_\_\_

The participant does **NOT** take any medication on a routine basis: \_\_\_\_\_.

The participant takes the following medicines (Please include ALL medications and attach sheet for more): \*

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

**Signature** (Parent or Guardian for participant under 18) \_\_\_\_\_ Date \_\_\_\_\_

**To be Completed by Licensed Physician or State Approved Nurse Practitioner**

Name of Participant: \_\_\_\_\_  
Date of Examination (must be within last two years): \_\_\_\_\_.

In my opinion, this person's condition allows participation in active camp program subject to the following limitations, restrictions, treatment to be continued at the camp:

**Signature of Licensed Health Care Provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print name and address of the above:** \_\_\_\_\_ **Phone:** \_\_\_\_\_